STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	I DDIG	00	COMPL	ETED
		155219		LDING		05/04/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	t			N IRONWOOD RD		
KINIDDEI	TDANCITIONAL (CARE AND REHAB-SOUTH BENI	`		I BEND, IN 46635		
KINDKEL	J TRANSITIONAL (CARE AND REHAB-SOUTH BENE	,	30011	1 BEND, IN 40033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was fo	r a Recertification and	F00	000	The facility requests that th	is	
	State Licensure Survey. This visit				plan of correction be		
		estigation of Complaints			considered its credible		
		00107262, IN00107366,			allegations of compliance.		
	IN00103018, IN	0010/202, 1110010/300,					
	1110010/048.				Submission of this respons	е	
					and Plan of Correction is no	ot a	
	•	105618 - Substantiated.			legal admission that a		
	Federal/state deficiencies related to the allegations are cited at F282.				deficiency exists or that this	3	
					statement of deficiency was	3	
	_				correctly cited and is also n	ot	
	Complaint IN00	107262 - Substantiated.			to be construed as an		
	•	iciencies related to the			admission of interest agains	st	
					the facility, the Administrate	or,	
	anegations are ci	ited at F203 and F250.			or any employee, agents, o	r	
	Commissing INIOO	107266 Salastantiatad			other individuals who draft	or	
	•	107366 - Substantiated.			may be discussed in the		
		iciencies related to the			response and Plan of		
	_	ited at F223, F225, F226			Correction. In addition,		
	and F250.				preparation and submissior	n of	
					the Plan of Correction does	;	
	*	107648 - Substantiated.			not constitute an admission	or	
	Federal/state def	iciencies related to the			agreement of any kind by the	ne	
	allegations are ci	ited at F323 and F498.			facility of the truth of any fa	cts	
					alleged or the corrections o	f a	
	Survey dates: A	pril 29, 30, May 1, 2, 3,			conclusions set forth in this		
	and 4, 2012	prin 27, 50, iviay 1, 2, 3,			allegation by the survey		
	anu 4, 2012				agency.		
		222424					
	Facility number:				Accordingly, the facility has		
	Provider number	:: 155219			prepared and submitted this	s	
	AIM number:	100266730			Plan of Correction prior to t	he	
					resolution of appeal of this		
	Survey team:				matter solely because of the	е	
	Sandra Haws, R	N - TC			requirements under State a	ınd	
	Banura Haws, Ki	N - 1C			Federal law that mandates		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		155219	B. WIN			05/04/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEI	R			N IRONWOOD RD	
KINDREI	O TRANSITIONAL	CARE AND REHAB-SOUTH BEN	D		BEND, IN 46635	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Vicki Manuwal,	RN			submission of the Plan of	
	Marcia Mital, R	N			Corrections a condition to	
	(4/30, 5/1, 5/2, 2012)				participate in the Title 18 an	nd
	Regina Sanders,	-			Title 19 programs. The	
	(4/30, 5/1, 5/2, 2012)				submission of Plan of	
ı	(1/30, 3/1, 3/2, 2				Correction within this	
	Congra had been				timeframe should in no way	be
	Census bed type: SNF/NF 108				of non-compliance or	
					admission by the facility.	
	Total: 108					
	Census payor type:					
	Medicare 14					
	Medicaid 70					
	Other 24					
	Total: 108					
	Sample: 22					
	Supplemental sa	imple: 9				
	These deficienci	es reflect state findings				
	cited in accordar	nce with 410 IAC 16.2.				
		- 11 1 10 1				
	` '	5/11/12 by Suzanne				
	Williams, RN					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155219 A. BUILDING B. WING OD O5/04/2012 O5/04/2012	
155219 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE	012
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER	
KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND SOUTH BEND, IN 46635	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COLUMN	COMPLETION
'	DATE
FO203 483.12(a)(4)(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISC/HARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the Items described in paragraph (a)(5)(ii) of this section. Except when specified in paragraph (a)(5)(ii) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or resident has not resided in the facility or 30 days. The written notice specified in paragraph (a) (4) of this section resident is transferred or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a) (4) of this section resident is transferred or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV						
A	ND PLAN (F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
			155219	B. WIN	G		05/04/	2012
		ROVIDER OR SUPPLIER	CARE AND REHAB-SOUTH BEND		52654 N	ADDRESS, CITY, STATE, ZIP CODE N IRONWOOD RD I BEND, IN 46635		
(X4) ID	SUMMARY S	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
]	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
	TAG		LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE
		facility residents disabilities, the nate telephone number of the protection developmental ID Bill of Rights Act residents who are address and teles responsible for the protection are address and teles responsible for the facility failed family was given alternative places informed the residents who are address and teles responsible for the facility failed family was given alternative places informed the residuscharged or proposed for the facility failed family was given alternative places informed the residuscharged or proposed for the facility of the facility failed family was given alternative places. The facility of the facility failed family was given alternative places informed the residuscharged or proposed for the facility of the fa	Disabilities Assistance and c; and for nursing facility re mentally ill, the mailing sphone number of the agency he protection and advocacy lividuals established under not Advocacy for Mentally Ill ews and record review, it to ensure a resident's nample notice to find ment after being ident needed to be evide the family with a fer or Discharge to inform heal rights for 1 of 5 and for discharge in a Resident # E) second record was 12 at 1:40 p.m. The indicated diagnoses of, by senile dementia, onephritis. The recordident was admitted to the	F02	03	1. Resident E was discharged from the facility prior to the survey. 2. All residents with discharge potential have the potential to be affected. A facil audit of discharge potential wil conducted, and a 30 day notic discharge will be presented whearranted. 3. The Interdisciplinary Team was inserviced on the policy and procedure for transfer/discharge including documentation of actions taken toward discharge Social Service Director/design will audit all residents for chan in discharge potential through clinical meeting weekly for necessity of issuance of the required notice of discharge. The log will be reviewed month X 6 months in the facility's	ity I be e of nen ge e. ee ges The I as II	06/09/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155219	B. WIN	IG		05/04/2012
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE	
					N IRONWOOD RD	
KINDREI	D TRANSITIONAL (CARE AND REHAB-SOUTH BEN	ID	SOUTH	I BEND, IN 46635	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
		inimum data set)			Performance Improvement Committee meeting to ensure	
	assessment dated 7/21/11, indicated her				100% compliance with notice	of
	_	oderately impaired, she			discharge is issued as required	
		ssistance with 1 staff for				
	transfers, and supervision/oversight with					
	ambulation. She required extensive					
	assistance with dressing, and bathing. The					
		she was frequently				
	incontinent of her bowel and bladder function.					
	The resident's record indicated a plan of					
		11 indicating the resident				
		lopement and had a				
	wanderguard in	place. The interventions				
	included; "Wand	derguard in place at all				
	times, check place	cement, encourage				
	participation in a	areas frequented by staff,				
	redirect as neede	ed and to document any				
	attempts to leave	e, notify M.D. (medical				
	doctor)/ family."	•				
	Elopement risk e	evaluations completed				
	quarterly indicat	ed an assessment				
	completed on 1/2	1/11, documented				
	"Resident is curr	rently Hospice makes no				
	attempts to wand	der or has made no				
	attempts for elop	pement, continues to wear				
	wanderguard."					
] , ,					
	_	sk evaluation dated				
		ed "Resident attempting				
		g to all the doors.				
	Wanderguard on	w/c (wheelchair) and				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155219	B. WIN			05/04	/2012
NAME OF P	PROVIDER OR SUPPLIEI		_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIED	Λ		52654 N	N IRONWOOD RD		
KINDREI	O TRANSITIONAL	CARE AND REHAB-SOUTH BEN	D	SOUTH	BEND, IN 46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	placed on 15 mil	n (minute) checks."					
	Numana mata data	d 2/21/12 at 11:45 m m					
		ed 3/31/12 at 11:45 p.m.					
	indicated "Res exit seeking 'looking for my car' res opened an exit door but did						
		ide before staff responded directed her. 15 minute					
	checks initiated.						
	CHECKS HIIIIated.						
	Δ Social Service	e note dated 4/2/12 with a					
	notation of "late entry for 3/29/12" indicated "Res (resident) had reported						
	exit seeking 3/31/12 easily redirected.						
	_	in place. No further					
	-	lisoriented at times, staff					
	redirect as neede						
		ttend group programming					
	· · · · · · · · · · · · · · · · · · ·	of room). Family					
	,	t. Res is pleasant and					
	cooperative duri						
	cooperative duri	115 1110 11011					
	A nurses' note or	n 4/5/12 at 1:00 p.m.					
		attempts to elope made					
		nt/cooperative with staff."					
		1					
	An elopement ri	sk evaluation dated					
	•	l "Resident observed					
		down sidewalk pushing					
	_	y brought back into					
		ed on 1:1 supervision."					
		•					
	Interviews conducted through the						
		gation indicated the staff					
		indicated the alarm was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155219		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURV COMPLETED 05/04/2012		
	PROVIDER OR SUPPLIER	CARE AND REHAB-SOUTH BEN	52654 N	ADDRESS, CITY, STATE, ZIP CODE N IRONWOOD RD I BEND, IN 46635	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE COM	(X5) MPLETION DATE
IAU	sounding for 1 to investigation fur was seen by other parking lot and was seen by other parking lot and was receiving the elopement. Nurse note dated (3:10 a.m.) indicestart of shift. For and CNA. Return difficulties. DOI and ED (Executi to 1 started. War (right) ankle and checks cont. Will A Social Service (untimed) indicanoted/reported. For seeking behavior plan) in place. Sather than the continuuntimed, "Contarparty)/son at required facilitate family	2 minutes. The facility's ther indicated the resident or staff walking to the vas brought back into the dent's record indicated g 1:1 supervision after 4/8/12 timed 03:10 ated "Res left building at and outside by this writer ned to facility without N (Director of Nursing) we Director) notified. 1 aderguard in place to (R) functioning. 15 minute 1 cont to monitor." note dated 4/11/12 ated "No attempts to elope the expressing no exit of statements. CP (care affety measures continue." and on the same day, cated res RP (responsible duest of Administration to mtg (meeting) to discuss the and possible options to	IAU			DATE
	•	ty and meet her needs. or 4/13/12 at 4 p.m"				
	Director and the	de to Social Service Director of Nursing on .m. for Social Service				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155219	B. WIN			05/04/	2012
NAME OF F	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP CODE		
KINDDE		CADE AND DELIAD COLITILIDES	n		I IRONWOOD RD		
		CARE AND REHAB-SOUTH BEN	<u>ט</u>	SOUTH	BEND, IN 46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		he meeting that was held	+	IAG			DATE
		on 4/13/12. No notes					
	were provided.	m 4/13/12. No notes					
	were provided.						
	A piece of printe	er paper with a heading of					
	"Nursing facilities South Bend" was						
		list of 12 area nursing					
	· · · · · · · · · · · · · · · · · · ·	notation at the bottom					
		ented to family at					
	meeting on 4/13/12."						
	Nurses note dated 4/24/12 indicated "Discharged from facility, transport via						
	_	pany name) Personal					
	items with famil	y. Inventory sheet signed.					
	No further action	required."					
	During a phone i	nterview with the					
	resident's family	on 5/3/12 at 10:15 a.m.					
	she indicated the	facility only gave them a					
	week to get her o	out of the facility. She					
	indicated afterwa	ards she spoke with the					
		I found out she wasn't					
		ischarged like that. The					
	-	they both had to take off					
	_	cement quickly. She					
		sband who was the acting					
		ey had to call the area					
		help. She also indicated					
		met with them once on					
	<u>-</u>	20 to 30 minutes and					
	indicated they left and didn't know what						
		y indicated the facility					
	never informed t	hem there was a problem					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155219	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMPI 05/04 /	ETED
KINDREI		CARE AND REHAB-SOUTH BEND	52654 N SOUTH	ADDRESS, CITY, STATE, ZIP CODE N IRONWOOD RD I BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	13th). The family they had a choice to move her due indicated they we of Transfer or Difamily further inimiformed on April alternative puthey started look placement that we discharged 11 day April 2012. The resident's recurrent Transfer or Discharged The resident was During an interval Nursing regarding family not receive Transfer or Discharm, she indicated because the family placement yet and one if the resident Director of Nurst the facility who do resident as they family the needs. She in	until that day (April y stated they didn't feel e and didn't want to have to her age. The family ere never given a Notice scharge at any time. The dicated they were il 13th they needed to placement right away so ing and found alternative reek. The resident was sys later on the 24th of eord indicated a Notice of harge form in the record dated 4/24/12. It discharged on 4/24/12. It with the Director of ag Resident # E or the ring a 30 day Notice of harge, 5/3/12 at 9:10 ed they didn't have to, ly hadn't found d could have only issued at had a place to go. The ing also indicated it was decided to discharge the felt they could not meet adicated the family was in ras looking for a place to				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155219	B. WIN			05/04/	2012
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
			_		N IRONWOOD RD		
KINDREI		CARE AND REHAB-SOUTH BEN	ט	SOUTH	I BEND, IN 46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG		interview with the	+	IAU			DATE
		arding the discharge of					
	1	5/3/12 at 10:23 a.m., she					
	· ·	oke with the family after					
	_	eeting with the facility.					
	_	indicated she then met					
		s Social Service Director					
	-						
	regarding the concern the family had with the resident's discharge. The Ombudsman						
		formed the Social Service					
	Director that he needed to issue the family a 30 day Notice of Transfer or Discharge.						
	_	of Transfer of Discharge.					
		notice the resident had					
		to another facility.					
	been transferred	to another facility.					
	On 5/4/12 at 10:2	20 a.m. interview with					
	the family indica	ted they wanted to					
		f a letter the resident's					
		ent to the corporate office					
		shed discharge without					
	assistance from t	he facility. The letter					
		2 and indicated "To					
	Whom it may co	ncern, I have been					
		ed to find another facility					
	for my Mother (I	Resident # E) who resides					
	at (facility name	and address). On April 6,					
	, ,	was found outside of					
	their building in	the evening hours by					
	staff members th	at were coming into					
	work. We were informed that when a staff						
	member was going out of the building,						
		wed them out as the door					
	1 -	ly close. As I am					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155219	LDING	NSTRUCTION 00	(X3) DATE : COMPL 05/04/	ETED
	PROVIDER OR SUPPLIER	CARE AND REHAB-SOUTH BEND	STREET A 52654 N	DDRESS, CITY, STATE, ZIP CODE I IRONWOOD RD BEND, IN 46635	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	that I have to find one in (sic) not a Mother's admissi informed this was admitted for do not feel that in should be subject confuse her even questions in a fair place on 4/13/12 manager and a so informed that the not present (Administrator # 'I could but she w Mother cannot strong a staffing not understand the Mother cannot be room, however, quality of care are also been inform make other arran and I both work, a week" The let POA.	r safety, I am concerned d another facility, as this locked unit. On my on 2 years ago, I was not s not a locked unit. She Dementia at that time. I my Mother is a threat nor ted to a move that will more. I had many mily meeting that took with an LPN unit ocial worker. We were administrator, who was ministrator # 13) wants in I inquired to talk to 13), the nurse stated that will tell you that your ay here because we are. I believe that this is g issue and liability. I do not as a patient, my the forced to stay in her I am concerned about the end her well being. I have that I have a week to gements and as my wife this may take longer than efter was signed by the				
	reviewed on 5/3/ "D/C (discharge)	an of care dated 4/12/12 12 at 1:00 p.m., indicated plan uncertain/pending requires secured unit."				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155219	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 05/04	LETED
KINDREI		CARE AND REHAB-SOUTH BENI	52654 1	ADDRESS, CITY, STATE, ZIP COE N IRONWOOD RD I BEND, IN 46635	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	resident and fam decision making. (SS) (Social Serve education/training (as needed), Fact discharge, Revieresources with resources with resources or arrange for coneeded, provide prn."	red indicated "Assist ily as needed during process vices), Provide regrecommendations process available community resident/family. Refer and mmunity resources as reducation and support relates to Complaint				

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Event ID: NHV811

Facility ID: 000124

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	ILTIPLE CC	ONSTRUCTION	(X3) DATE COMPL	
AND PLAN	OF CORRECTION	155219	A. BUIL		00	05/04/	
		100210	B. WING		ADDRESS CITY STATE ZID CODE	00/01/	20.2
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE N IRONWOOD RD		
KINDREI	D TRANSITIONAL	CARE AND REHAB-SOUTH BEND			I BEND, IN 46635		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
F0223	483.13(b), 483.			TAG	,		DATE
SS=A	FREE FROM A SECLUSION The resident ha verbal, sexual,	BUSE/INVOLUNTARY as the right to be free from physical, and mental abuse, ment, and involuntary					
	sexual, or physi	st not use verbal, mental, ical abuse, corporal involuntary seclusion.					
	Based on interv	iew and record review, the	F022	23	Resident F has been		06/09/2012
	facility failed to	ensure residents were			discharged from the facility. 2. other residents with an allegat		
	free from physic	cal and verbal abuse by			of abuse have the potential to		
	facility staff for	1 of 7 residents reviewed			affected. Department Heads w		
	for abuse in a sa	ample of 22.			conduct interviews with		
	Resident # F				interviewable residents to determine outstanding issues. Administrator will act on these reports per policy. 3. All staff v		
	Findings include	e:			inserviced on the policies and procedures for responding to a	an	
	The clinical rec	ord for Resident # F was			allegation of abuse. The Administrator will review the		
	reviewed on 5/2	2/12 at 4:40 P.M. The			nature of all allegations to		
	resident's diagno	oses included, but were			determine if the criteria have		
	not limited to:	hypothyroidism,			been met for abuse and to ens	sure	
	hypertension, an	nd congestive heart failure.			timely execution of related policies and procedures. Department Heads will intervie	. W	
	Review of a "Re	esident Progress Notes"			5 residents per week to	- -	
		ndicated, "Resident			determine outstanding allegati		
	· ·	that someone was being			of abuse. 4. The Administrator will audit all allegations. The a		
	_	ner, rolling her around in			will be reviewed monthly X 6	uuit	
		ated that this person was			months in the facility's		
		or going to the bathroom in			Performance Improvement		
	her brief. Son v				Committee meeting to ensure 100% compliance. The facility		
	Review of a "In	cident Report Form" dated			respectfully requests an IDR for this citation. The event cited w		

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Event ID: NHV811

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		155219	B. WIN			05/04/2012	
			1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	· ·		52654 N	N IRONWOOD RD		
KINDREI	D TRANSITIONAL (CARE AND REHAB-SOUTH BENE)	SOUTH	BEND, IN 46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		ON
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	DATE	
	· ·	the Indiana State			not substantiated as cited as p facility investigation of the eve		
	•	Iealth, indicated, "			lability investigation of the eve		
	[Resident # F] states she was moved						
	roughly during the night by a woman with						
		pice. Upon interview,					
	1	tates that [CNA # 14] was					
	rough with her w	while rolling her in the					
	bed and that she	scolded her for "making					
	a mess." [CNA	# 14] states she provided					
	care to Resident	# F gently, and denies					
	scolding her for	soiling herself. Staff,					
	residents, and fa	milies of residents to					
	whom [CNA # 1	4] provides care do not					
	have issues with	her care[CNA # 14]					
		ing investigation.					
		tiated. MD & family					
	_	14] re-educated. She					
	_	d to her position with					
		monitored by nurse					
		provision of care per					
	_	ervices will continue to					
		nt # F's] psychosocial					
		int # 1 s] psychosocial					
	well-being"						
	Review of a faci	lity "Alleged Abuse,					
		ploitation Investigation					
	1	ed 1/11/12, indicated,					
	"Physical Abu						
	1	t stated that someone					
		was being rough c her					
		round in her bed roughly.					
		his person was yelling at					
	her for 'making a						
	briefCNA sus	pended pending	<u>L</u>				

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		IDENTIFICATION NUMBER: 155219	A. BUILDI B. WING		00	COMPLETED 05/04/2012	
	PROVIDER OR SUPPLIER	CARE AND REHAB-SOUTH BEND	5	2654 N	DDRESS, CITY, STATE, ZIP CODE I IRONWOOD RD BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	Investigation" re "A staff memb abuse/neglect sit discipline, will b removed from ar Interviewed and documented c. investigation resi	esident During An vised 4/28/09, indicated, er implicated in an uation, regardless of e: a. Immediately ny resident contact b. version of event Suspended pending					

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Facility ID: 000124

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIMES	NC	00	COMPL	ETED
		155219	A. BUILDI	ING		05/04/	2012
			B. WING	TENEET A	DDDEGG GITY GTATE ZID GODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
KINDDE	D TO A NOITIONIAL A	CARE AND RELIAD COUTLINEND			I IRONWOOD RD		
KINDREL) TRANSITIONAL (CARE AND REHAB-SOUTH BEND	' [SOUTH	BEND, IN 46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	7	ΓAG	DEFICIENCY)	-	DATE
F0225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)					
SS=D	INVESTIGATE/F	REPORT					
	ALLEGATIONS/						
		not employ individuals who					
		d guilty of abusing,					
		istreating residents by a court					
		nad a finding entered into the					
		registry concerning abuse, tment of residents or					
		of their property; and report					
		t has of actions by a court of					
	, ,	employee, which would					
	_	s for service as a nurse aide					
		staff to the State nurse aide					
	registry or licens	sing authorities.					
	violations involvi abuse, including and misappropri reported immedi the facility and to with State law th procedures (incl certification age. The facility must alleged violation and must prever while the investignated reported to the adesignated reproficials in accordincluding to the agency) within 5	ensure that all alleged ing mistreatment, neglect, or injuries of unknown source ation of resident property are lately to the administrator of cother officials in accordance brough established uding to the State survey and lancy). Thave evidence that all so are thoroughly investigated, in further potential abuse gation is in progress. I investigations must be administrator or his esentative and to other dance with State law State survey and certification is working days of the incident, individual in the verified.					
	* * * *	ective action must be taken.	F0225	.	1 For Docident D. alleged		06/00/2012
		review and interview, the ensure staff responded	F0223		For Resident B, alleged perpetrator was suspended pending results of investigation	٦.	06/09/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED
155219 B. WING	05/04/2012
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 52654 N IRONWOOD RD	
KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND SOUTH BEND, IN 46635	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION
	DATE
correctly to an allegation of abuse for 1 of Administrator was notified of incident, the investigation was	
completed and the incident was	
not calling the Administrator, protecting reported to the Indiana State	
the resident from further potential abuse, Department of Health during the	
completing a thorough investigation, and survey.2. All other residents w	
reporting the allegation to the Indiana an allegation of abuse have the potential to be affected.	e
State Department Health, for 1 of 7 Department Heads will conduct	et
residents reviewed for abuse in a sample interviews with interviewable	
of 22. (Resident B) residents to determine	
outstanding issues. Administra	ator
Findings include: will act on these reports per	
policy. 3. All staff was inservice on the policies and procedures	
1. Resident B's record was reviewed on responding to an allegation of	3 101
4/30/12 at 1:10 p.m., Resident B's abuse. The Administrator will	
diagnoses included but were not limited review the nature of all allegat	
to determine in the Criteria have	
	sure
osteoporosis. timely execution of related policies and procedures.	
Department Heads will intervie	ew
A Quarterly MDS (minimum data set) 5 residents per week to	
assessment, dated 2/8/12, indicated the determine outstanding allegati	
resident had moderate cognitive of abuse.4. The Administrator will audit all allegations. The a	
mipariment and the resident required will be reviewed monthly Y 6	uuit
extensive assistance of two staff members months in the facility's	
for bed mobility and transfers. Performance Improvement	
Committee meeting to ensure	
During an interview on 4/30/12 at 12:45	
p.m., LPN #1 indicated yesterday	
afternoon (Sunday) she had received a	
phone call from the Weekend Manager,	
RN #2. She indicated RN #2 had tried to	
call the Director of Nurses (DoN), but	
was not able to reach her so RN #2 had	
called her. She indicated RN #2 had told	
her Resident B had reported a CNA had	

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI	
		155219	B. WIN	IG		05/04	/2012
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
KINIDDE		0.05 AND DELLAR COLUEN DEL			I IRONWOOD RD		
KINDREI	J TRANSITIONAL (CARE AND REHAB-SOUTH BEN	שו	SOUTH	BEND, IN 46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	~	e indicated there had been					
		e room at the time. She					
		sident had stated the					
		e resident "Your yelling					
		we to take this from you."					
	She indicated the	e resident had said the					
	CNA who had y	elled at her was not the					
	CNA taking care	e of her that day. She					
	indicated she had	d told RN #2 to get					
	statements from	both CNAs. She					
	indicated RN #2	had talked to both CNAs					
	and CNA #3 was	s the CNA the resident					
	had said yelled a	at her. She indicated she					
	had told RN #2 1	not to let CNA #3 go into					
		m anymore and to have					
		in pairs. She indicated					
		the resident when she					
		this morning (Monday)					
		had said "more or less					
		ng on." She indicated she					
		the Administrator. She					
		IA had not been sent					
		eated the CNA had					
		rk but did not take care of					
	Resident B.	ix but did not take care or					
	Resident D.						
	During an inters	iew on 4/30/12 at 1 p.m.,					
	_	or indicated she had not					
		f any allegations of abuse					
		i any anegations of abuse					
	yesterday.						
	D since it is						
	_	iew on 4/30/12 at 1:02					
	_	dicated she had received					
	the call from RN	I #2 at about 4 p.m.					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155219	B. WIN			05/04/	/2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			I IRONWOOD RD		
		CARE AND REHAB-SOUTH BENE)		BEND, IN 46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
	yesterday.						
	_	iew on 4/30/12 at 1:04					
	p.m. the DoN indicated she was not aware						
	_	until a few minutes ago.					
		had not been reported to					
	Indiana State Department of Health.						
	During an interv	niew on 4/30/12 at 1:04					
	p.m., the Admin	istrator indicated the					
	CNA should have been suspended until						
	they investigated the allegation.						
	During an interv	iew on 4/30/12 at 1:30					
	p.m., RN #2 indi	icated Resident B had					
	•	on 4/29/12 the aides got					
	_	er in her chair and then					
		said "If you don't quit					
		oing to help you." RN #2					
	1	ident was not able to tell					
		e was. He indicated he					
		who was working with					
		day. He indicated the					
		d it was not her aide but					
		nd came in to help. He					
		talked to the resident's					
		and she had told him					
		resident into her chair the					
	_	an screaming at CNA #3					
		3 said she couldn't do this					
	and had stepped	out of the room. He					
	indicated he had	then went and talked to					
	CNA #3. He ind	dicated CNA #3 told him					
	she had been hel	ping with Resident B and					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DDIC	00	COMPL	ETED
		155219	A. BUII B. WIN	LDING		05/04/	/2012
		<u> </u>	b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R			N IRONWOOD RD		
KINDREI	TRANSITIONAL (CARE AND REHAB-SOUTH BEND)		BEND, IN 46635		
			<u> </u>		, DE113, III 16666		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		had began yelling so she					
		He indicated he had					
		t to take care of Resident					
	B. He indicated he had tried to call the						
	DoN but did not get an answer so he had called LPN #1. He indicated LPN #1 had						
	told him to fill out a grievance and to get						
		the CNAs. He indicated					
		the resident by not					
	_	into Resident B's room.					
		N #1 had not told him to					
	suspend anyone just told him to get statements from the CNAs.						
	statements from	the CNAS.					
	During an interv	iew on 4/30/12 at 1:35					
	_	indicated a CNA had					
	*	ne indicated two CNAs					
	*	up and one was pulling					
		other was pulling her the					
	-	indicated the CNA had					
	1	ng to stand here and					
	_	and yell and walked out					
		ne indicated she had					
		away but she was not sure					
	who she had rep	UNCU II IU.					
	A "Complaints/G	Grievances" form, dated					
		by RN #2, indicated					
		atient) reported that one of					
	`	into her room and told					
		-					
	her she would no quits yelling, scr left the room. U	onto her room and told of help her unless if she reaming, and crying and fpon investigation CNA orted she had asked					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155219			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED - 05/04/2012
KINDREI		CARE AND REHAB-SOUTH BEN	52654 I D SOUTH	ADDRESS, CITY, STATE, ZIP CO N IRONWOOD RD I BEND, IN 46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION
	the CNA who reshe had to leave screaming at her	pt started screaming at ported to the CNA that because pt was			

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER: 155219	A. BUI	LDING	00	COMPL 05/04/	
		100218	B. WIN		A DODEGO CHEN COLUE COLOR	03/04/	2012
NAME OF PR	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE N IRONWOOD RD		
KINDRED	TRANSITIONAL (CARE AND REHAB-SOUTH BE	ND		I BEND, IN 46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
F0226 SS=D	483.13(c) DEVELOP/IMPL ETC POLICIES The facility must written policies a mistreatment, ne residents and mi property. Based on record facility failed to o prevention policy implemented for abuse reviewed, Administrator, pr from further pote thorough investig allegation to the Health, for 1 of 7 abuse in a sample Findings include 1. Resident B's r 4/30/12 at 1:10 p diagnoses includ- to, diabetes melli osteoporosis. A Quarterly MD assessment, dated resident had mod impairment and t	MENT ABUSE/NEGLECT, develop and implement and procedures that prohibit eglect, and abuse of sappropriation of resident review and interview, the ensure their abuse y and procedure was 1 of 4 allegations of related to not calling the rotecting the resident ential abuse, completing a gation, and reporting the Indiana State Department residents reviewed for e of 22. (Resident B) : record was reviewed on o.m., Resident B's ed, but were not limited itus, hypertension, and S (minimum data set) d 2/8/12, indicated the derate cognitive the resident required ince of two staff members	F02		1. For Resident B, alleged perpetrator was suspended pending results of investigation Administrator was notified of incident, the investigation was completed, and the incident w reported to the Indiana State Department of Health during t survey.2. All other residents wan allegation of abuse have the potential to be affected. Department Heads will conduct interviews with interviewable residents to determine outstanding issues. Administra will act on these reports per policy. 3. All staff was inservice on the policies and procedure responding to an allegation of abuse. The Administrator will review the nature of all allegate to determine if the criteria have been met for abuse and to ensitimely execution of related policies and procedures. Department Heads will interview 5 residents per week to determine outstanding allegated of abuse.4. The Administrator will audit all allegations. The awill be reviewed monthly X 6 months in the facility's Performance Improvement	as he with he ct ator ced s for tions e sure ew ions	06/09/2012

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			X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155219	B. WIN	G		05/04/	2012
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
KINDDE	D TDANIOITIONAL (DADE AND DELLAR COUTURES	_		N IRONWOOD RD		
KINDREI	J TRANSITIONAL (CARE AND REHAB-SOUTH BENI	ر 	SOUTH	I BEND, IN 46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	·		DATE
	_	iew on 4/30/12 at 12:45			100% compliance.		
	•	dicated yesterday					
	,	ay) she had received a					
	_	the Weekend Manager,					
		cated RN #2 had tried to					
		of Nurses (DoN), but					
		each her so RN #2 had					
		ndicated RN #2 had told					
		ad reported a CNA had					
		e indicated there had been					
		room at the time. She					
indicated the Resident had stated the							
	CNA had told th	e resident "Your yelling					
	at me. I don't ha	ve to take this from you."					
	She indicated the	e resident had said the					
	CNA who had yo	elled at her was not the					
	CNA taking care	of her that day. She					
	indicated she had	d told RN #2 to get					
	statements from	both CNAs. She					
	indicated RN #2	had talked to both CNAs					
	and CNA #3 was	s the CNA the resident					
	had said yelled a	t her. She indicated she					
	had told RN #2 r	not to let CNA #3 go into					
	Resident B's roo	m anymore and to have					
		in pairs. She indicated					
		the resident when she					
	came into work t	this morning (Monday)					
		had said "more or less					
	nothing was goir	ng on." She indicated she					
		the Administrator. She					
	indicated the CN	A had not been sent					
	home. She indic	ated the CNA had					
		k but did not take care of					
	Resident B.						

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Event ID: NHV811

Facility ID: 000124

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155219	B. WIN	G		05/04/	2012
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
			_		N IRONWOOD RD		
KINDREL) TRANSITIONAL (CARE AND REHAB-SOUTH BENI)	SOUTH	BEND, IN 46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DLI ICILIACT)		DATE
	D	4/20/12 - 4.1					
	_	iew on 4/30/12 at 1 p.m.,					
		or indicated she had not					
		f any allegations of abuse					
	yesterday.						
	During on inta-	iew on 4/30/12 at 1:02					
		dicated she had received					
	_						
		I #2 at about 4 p.m.					
	yesterday.						
	During on inters	iew on 4/30/12 at 1:04					
		dicated she was not aware					
	1 ^						
	_	until a few minutes ago.					
		had not been reported to					
	indiana State De	partment of Health.					
	During on inters	iew on 4/30/12 at 1:04					
	_	istrator indicated the					
	1 * '	re been suspended until					
	they investigated	-					
	l mey investigated	i the anegation.					
	During an interv	iew on 4/30/12 at 1:30					
	_	icated Resident B had					
	1 * '	on 4/29/12 the aides got					
		er in her chair and then					
		said "If you don't quit					
		oing to help you." RN #2					
	1	ident was not able to tell					
		e was. He indicated he					
		who was working with					
		day. He indicated the					
		d it was not her aide but					
		id came in to help. He					
	Someone who ha	id came in to help. The	1				

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	OF CORRECTION IDENTIFICATION NUMBER: 155219	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/04/2012
	PROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHAB-SOUTH BEND	52654 N	DDRESS, CITY, STATE, ZIP CODE I IRONWOOD RD BEND, IN 46635	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	indicated he had talked to the resident's CNA (CNA #4) and she had told him after getting the resident into her chair the resident had began screaming at CNA #3 and then CNA #3 said she couldn't do this and had stepped out of the room. He indicated he had then went and talked to CNA #3. He indicated CNA #3 told him she had been helping with Resident B and then Resident B had began yelling so she had left the room. He indicated he had told CNA #3 not to take care of Resident B. He indicated he had tried to call the DoN but did not get an answer so he had called LPN #1. He indicated LPN #1 had told him to fill out a grievance and to get statements from the CNAs. He indicated he had protected the resident by not letting CNA go into Resident B's room. He indicated LPN #1 had not told him to suspend anyone just told him to get statements from the CNAs. During an interview on 4/30/12 at 1:35 p.m., Resident B indicated a CNA had yelled at her. She indicated two CNAs were getting her up and one was pulling one way and the other was pulling her the other way. She indicated the CNA had said "I'm not going to stand here and listen to you cry and yell and walked out of the room." She indicated she had reported it right away but she was not sure who she had reported it to.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155219			LDING	NSTRUCTION 00	(X3) DATE : COMPL 05/04/	ETED	
	PROVIDER OR SUPPLIER	CARE AND REHAB-SOUTH BENI)	52654 N	DDRESS, CITY, STATE, ZIP CODE I IRONWOOD RD BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	4/29/12, signed by "IssuesPt (Pathe CNAs came her she would not quits yelling, scrileft the room. Ut assisted to pt repanother CNA to care/transfer and the CNA who reshe had to leave screaming at her. A facility policy: 10/26/11, received current, indicated violations involving immediately to the facility and to other accordance with. A facility policy: Resident During 04/28/09, received current, indicated are taken to protein investigation of a implicated in an regardless of discimmediately remanded. Interest.	pt started screaming at ported to the CNA that because pt was ." titled "Abuse", dated ed from the DoN as d "All alleged ingabuseare reported the administrator of the ther officials in					

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PRINTED: 06/13/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND SOUTH BEND, IN 46935 SOUTH BEND,	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Pending investigation results" A facility policy, titled "Conducting an Investigation", dated 06/30/06, received from the DoN as current, indicated "The investigationSpecify the type of allegation that is being reportedDocument the details of the incidentInterview staff members, visitors and/or residents who may have knowledge of alleged incidentStaff that cared for the resident(s) at the time of alleged incidentResidents in the same room, or residents in the immediate vicinity of where the alleged incident occurred who might have seen or heard somethingVisitors who might have witnessed the incident" This Federal tag relates to Complaint IN00107366.								
KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND X(4) ID SUMMARY STATEMENT OF DEFICIENCIES ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Dending investigation results" A facility policy, titled "Conducting an Investigation", dated 06/30/06, received from the DoN as current, indicated "The investigationSpecify the type of allegation that is being reportedDocument the details of the incidentInterview staff members, visitors and/or residents who may have knowledge of alleged incidentStaff that cared for the resident(s) at the time of alleged incidentResidents in the same room, or residents in the immediate vicinity of where the alleged incident occurred who might have seen or heard somethingVisitors who might have witnessed the incident" This Federal tag relates to Complaint IN00107366.				B. WIN		DDRESS CITY STATE 7IP CODE		
CX4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Part TAG PROVIDERS PLAN OF CORRECTION BIOLIDES PLAN OF CORRECTION BIOLIDES PLAN OF COMPLETION DATE A facility policy, titled "Conducting an Investigation", dated 06/30/06, received from the DoN as current, indicated "The investigation that is being reportedDocument the details of the incidentInterview staff members, visitors and/or residents who may have knowledge of alleged incidentStaff that cared for the resident(s) at the time of alleged incidentStaff that cared for the resident(s) at the time of alleged incidentStaff that cared who might have seen or heard somethingVisitors who might have witnessed the incident" This Federal tag relates to Complaint IN00107366.	NAME OF P	ROVIDER OR SUPPLIER						
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Pending investigation results" A facility policy, titled "Conducting an Investigation", dated 06/30/06, received from the DoN as current, indicated "The investigationSpecify the type of allegation that is being reportedDocument the details of the incidentInterview staff members, visitors and/or residents who may have knowledge of alleged incidentStaff that cared for the resident(s) at the time of alleged incidentResidents in the same room, or residents in the immediate vicinity of where the alleged incident occurred who might have seen or heard somethingVisitors who might have witnessed the incident" This Federal tag relates to Complaint IN00107366.	KINDRE	TRANSITIONAL (CARE AND REHAB-SOUTH BEND)				
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Pending investigation results" A facility policy, titled "Conducting an InvestigationSpecify the type of allegation that is being reportedDocument the details of the incidentInterview staff members, visitors and/or residents who may have knowledge of alleged incidentStaff that cared for the resident(s) at the time of alleged incidentResidents in the same room, or residents in the immediate vicinity of where the alleged incident occurred who might have seen or heard somethingVisitors who might have witnessed the incident" This Federal tag relates to Complaint IN00107366.	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
pending investigation results" A facility policy, titled "Conducting an Investigation", dated 06/30/06, received from the DoN as current, indicated "The investigationSpecify the type of allegation that is being reportedDocument the details of the incidentInterview staff members, visitors and/or residents who may have knowledge of alleged incidentStaff that cared for the resident(s) at the time of alleged incidentResidents in the same room, or residents in the immediate vicinity of where the alleged incident occurred who might have seen or heard somethingVisitors who might have witnessed the incident" This Federal tag relates to Complaint IN00107366.		*				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
A facility policy, titled "Conducting an Investigation", dated 06/30/06, received from the DoN as current, indicated "The investigationSpecify the type of allegation that is being reportedDocument the details of the incidentInterview staff members, visitors and/or residents who may have knowledge of alleged incidentStaff that cared for the resident(s) at the time of alleged incidentResidents in the same room, or residents in the immediate vicinity of where the alleged incident occurred who might have seen or heard somethingVisitors who might have witnessed the incident" This Federal tag relates to Complaint IN00107366.	TAG		·		TAG	DEFICIENCY)		DATE
Investigation", dated 06/30/06, received from the DoN as current, indicated "The investigationSpecify the type of allegation that is being reportedDocument the details of the incidentInterview staff members, visitors and/or residents who may have knowledge of alleged incidentStaff that cared for the resident(s) at the time of alleged incidentResidents in the same room, or residents in the immediate vicinity of where the alleged incident occurred who might have seen or heard somethingVisitors who might have witnessed the incident" This Federal tag relates to Complaint IN00107366.		pending investig	ation results"					
		A facility policy, Investigation", defrom the DoN as investigationSpallegation that is reportedDocum incidentInterviewisitors and/or reknowledge of all cared for the resignalleged incident room, or resident vicinity of where occurred who missomethingVisit witnessed the incomplete that the second of the resignal incident This Federal tag IN00107366.	titled "Conducting an ated 06/30/06, received current, indicated "The becify the type of being ment the details of the ew staff members, esidents who may have eged incidentStaff that dent(s) at the time ofResidents in the same at in the immediate ethe alleged incident ght have seen or heard tors who might have eddent"					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. BUILDING 00			COMPLETED	
		155219	B. WIN			05/04/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				N IRONWOOD RD		
KINDRED	TRANSITIONAL (CARE AND REHAB-SOUTH BEND			I BEND, IN 46635		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0250 SS=D	SOCIAL SERVIC	MEDICALLY RELATED CE provide medically-related					
		o attain or maintain the					
		ble physical, mental, and					
		II-being of each resident.					
	Based on record	reviews and interviews,	F02	50	1. Residents E & F were		06/09/2012
		to provide social			discharged from the facility pri	or	
	_	necessary assistance and			to the survey. 2. All other residents and families requiring medically-related social services		
		sident and family					
	_	ce with discharge from			have the potential to be affected		
	_	o elopement behaviors for			Social Service Director/designee		
	_	eviewed for discharge			will review all residents for the		
		nd failing to provide the			necessity of these services an establish a plan of care for	d	
	, ,	-up to evaluate the			provision of the services as		
		Il being of a resident			required. 3. Social Service		
		se allegation, for 1 of 7			Department was inserviced on	1	
		ed for abuse in a sample			establishing a plan of care for	\n	
	of 22. (Resident	•			provision of and implementation of required medically-related	וונ	
	of 22. (Resident	" '			social services. Social Service		
	Findings include	:			Director will review all resident for appropriate assessment ar documentation through clinica	nd	
	1. Resident # E's	s closed record was			meeting weekly and at least		
	reviewed on 5/2/	12 at 1:40 p.m. The			quarterly through the care		
	resident's record	indicated diagnoses of,			planning process to determine necessity of medically-related		
		o; senile dementia,			social services. 4. Social Serv	vice	
		onephritis. The record			Director will review 10 charts		
	1.5	ident was admitted to the			monthly for assessment and		
	facility on 4/16/1				documentation of		
					medically-related social service		
	Review of Resid	ent # E's Significant			intervention. These results will reviewed monthly X 6 months		
	change MDS (m	•			the facility's Performance		
	`	· ·			Improvement Committee meet	ing	
		17/21/11, indicated her			to ensure 100% compliance.	-	
	cognition was me	oderately impaired, she					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT	SURVEY ETED			
111,512,111	or confidence.	155219	A. BUILDI	NG	00	05/04/2	
			B. WING	TREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			N IRONWOOD RD		
		CARE AND REHAB-SOUTH BEN			BEND, IN 46635		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		EFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		assistance with 1 staff for	1	IAG	,		DATE
		pervision/oversight with					
	· ·	e required extensive					
		dressing, and bathing. The					
		she was frequently					
		er bowel and bladder					
	function.	or oo wer and orduder					
	A Social Service	e note dated 4/2/12, with a					
		e entry for 3/29/12,"					
		s (resident) had reported					
		1/12 easily redirected.					
	1	s in place. No further					
	1 -	lisoriented at times, staff					
	redirect as need						
	(occasionally) a	ttend group programming					
	1 ` ' '	it of room). Family					
	`	t. Res is pleasant and					
	cooperative duri	ing this visit"					
	A nurse's note o	n 4/5/12 1:00 p.m.,					
	indicated "No	attempts to elope made					
	this shift. Pleasa	ant/cooperative with staff."					
	1 *	sk evaluation dated					
		d "Resident observed					
		down sidewalk pushing					
		ly brought back into					
		ed on 1:1 supervision."					
	1	aff, documented with the					
	'	gation, all indicated the					
		ding for 1 to 2 minutes.					
		indicated she was seen by					
	I other staff walki	ing to the parking lot and					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	OO	(X3) DATE (COMPL	
ANDILAN	OF CORRECTION	155219	1	LDING	00	05/04/	
		100210	B. WIN		DDDDGG GYMY GMARE GYD GODD	00/04/	2012
NAME OF I	PROVIDER OR SUPPLIER	t.			ADDRESS, CITY, STATE, ZIP CODE N IRONWOOD RD		
KINDREI	O TRANSITIONAL (CARE AND REHAB-SOUTH BEN	D		BEND, IN 46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		k into the facility. The					
		indicated she was					
	receiving 1:1 sup	pervision.					
	A nurse note date	ed 4/8/12 timed 03:10					
	(3:10 a.m.), indic	cated "Res left building at					
		and outside by this writer					
		ned to facility without					
		N (Director of Nursing)					
		ve Director) notified. 1					
	`	nderguard in place to (R)					
		functioning. 15 minute					
		l cont to monitor."					
	A Social Service	note dated 4/11/12					
		ated "No attempts to					
	` ' '	rted. Res expressing no					
		avior statements. CP					
		ice. Safety measures					
		note continued on the					
		ed, "Contacted res RP					
		y)/ son at request of					
		o facilitate family mtg					
		russ res elopement risk					
		ions to promote her safety					
		eds. Mtg scheduled for					
	4/13/12 at 4 p.m.	_					
	w - p.m.						
	During a phone i	nterview with the					
		arding the discharge of					
		5/3/12 at 10:23 a.m., she					
	· ·	d spoke to the family and					
		e facility's Social Service					
	Director regardir	•					
		-0 1 40.44.40					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	OO	(X3) DATE COMPL		
ANDILAN	OF CORRECTION	155219	A. BUI	LDING	00	05/04/	
		133219	B. WIN			03/04/	2012
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
KINIDDEI	TDANSITIONAL (CARE AND REHAB-SOUTH BEN	n		N IRONWOOD RD BEND, IN 46635		
			J		DEND, IN 40033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		<u> </u>	+	TAG	BEHTELENCTY		DATE
	-	Ombudsman indicated					
		cial Service Director that					
		ie the family a 30 day					
		er or Discharge. The					
		ther indicated she was					
		ce the resident had been					
	transferred to and	other facility.					
		iew with the Social					
		on 5/3/12 at 11:45 a.m.					
	regarding Reside	ent # E's discharge, he					
	indicated he gave	e the family a list of other					
	facilities for then	n to look into on April					
	13th when he me	et with the family to					
	discuss the reside	ent's discharge. The					
	Social Service D	rirector indicated he					
	recalled meeting	with the Ombudsman					
	and the informat	ion given to him about					
	the need to issue	the 30 day notice to the					
	family, but he fe	lt it wasn't necessary.					
	Request was mad	de to the Social Service					
	_	Director of Nursing on					
	5/3/12 at 12:00 p	o.m. for Social Service					
	_	the meeting that was held					
		on 4/13/12, no notes were					
	provided.	,					
	F						
	A piece of printe	er paper with a heading of					
		es South Bend" was					
		list of 12 area nursing					
		notation at the bottom					
		ented to family at					
		-					
	meeting on 4/13/	12.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	COMPL		
1111212111	or condition,	155219		LDING		05/04/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	R			N IRONWOOD RD		
KINDREI	O TRANSITIONAL (CARE AND REHAB-SOUTH BEN	D	SOUTH	BEND, IN 46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Name and date	1 1/21/12 in diament					
		d 4/24/12, indicated					
	_	n facility, transport via pany name) Personal					
	l '	y. Inventory sheet signed.					
	No further action						
	140 Iuruici actioi	i required.					
	During a phone i	interview with the					
	_ ^	on 5/3/12 at 10:15 a.m.					
		facility only gave them a					
		out of the facility. She					
	indicated afterwa	ards she spoke with the					
	Ombudsman and	I found out she wasn't					
	supposed to be d	ischarged like that. The					
	family indicated	they both had to take off					
	work to find plac	cement quickly. She					
	indicated her hus	sband who was the acting					
	Power of Attorne	ey had to call the area					
	Ombudsman for	help. She also indicated					
	the facility only	met with them once on					
	4/13/12 for only	20 to 30 minutes and she					
	indicated they le	ft and didn't know what					
		y indicated the facility					
		hem there was a problem					
		until that day. The					
	I -	ey didn't feel they had a					
		t want to have to move					
	_	e. The family indicated					
	_	given a Notice of					
	Transfer or Disc	harge at any time.					
	The resident's re-	cord indicated a Notice of					
		harge form in the					
		record dated 4/24/12.					
	restuent s closed	100010 uateu 4/24/12.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155219		LDING	NSTRUCTION 00	(X3) DATE COMPL 05/04/	ETED	
	PROVIDER OR SUPPLIER	L CARE AND REHAB-SOUTH BEN	52654 N	DDRESS, CITY, STATE, ZIP CODE I IRONWOOD RD BEND, IN 46635	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	On 5/4/12 at 10:2 the family indical provide a copy of son (POA) had so regarding the rust assistance from the dated 4/14/12 and may concern, I have to find another (Residen (facility name and 2012 my Mother their building in staff members the work. We were in member was going my Mother folloodid not complete concerned for he that I have to find one in (sic) not a Mother's admission in formed this was admitted for do not feel that in should be subject confuse her even questions in a fair place on 4/13/12 manager and a so informed that the	a discharged on 4/24/12. 20 a.m., interview with sted they wanted to f a letter the resident's ent to the corporate office shed discharge without he facility. The letter was d indicated "To Whom it have been notified that I her facility for my to the evening hours by at were coming into a staffing out of the building, wed them out as the door ly close. As I am resafety, I am concerned d another facility, as this locked unit. On my fon 2 years ago, I was not as not a locked unit. She home to a move that will a more. I had many mily meeting that took with an LPN unit ocial worker. We were administrator, who was ministrator # 13) wants				

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	OF CORRECTION OF CORRECTION 155219	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/04/2012
	PROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHAB-SOUTH BEND	52654 N	DDRESS, CITY, STATE, ZIP CODE I IRONWOOD RD BEND, IN 46635	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	her moved. When I inquired to talk to (Administrator # 13), the nurse stated that 'I could but she will tell you that your Mother cannot stay here because we are not a locked unit.' I believe that this is more of a staffing issue and liability. I do not understand that as a patient, my Mother cannot be forced to stay in her room, however, I am concerned about the quality of care and her well being. I have also been informed that I have a week to make other arrangements and as my wife and I both work, this may take longer than a week" The letter was signed by the POA. The resident's plan of care dated 4/12/12, reviewed on 5/3/12 at 1:00 p.m., indicated "D/C (discharge) plan uncertain/pending at this time- Res requires secured unit." Interventions listed indicated " Assist resident and family as needed during decision making, D/C planning process (SS) (Social Services), Provide education/training/recommendations prn (as needed), Facilitate mtg prior to discharge, Review available community resources with resident/family. Refer and or arrange for community resources as needed, provide education and support prn." 2. The clinical record for Resident # F was reviewed on 5/2/12 at 4:40 P.M. The			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155219		(X2) MULTIPLE CO	00	COM	TE SURVEY IPLETED 04/2012	
		1.2.2	B. WING	ADDRESS SITE STATE STATE		
NAME OF I	PROVIDER OR SUPPLIEF	8		ADDRESS, CITY, STATE, ZIP C	ODE	
KINDRFI	O TRANSITIONAL (CARE AND REHAB-SOUTH BEN		N IRONWOOD RD I BEND, IN 46635		
				I		OV.5
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)		DATE
		ses included, but were				
	not limited to: h					
		d congestive heart failure.				
	in percention, with					
	Review of a "Re	sident Progress Notes"				
		idicated, "Resident				
	-	nat someone was being				
	_	er, rolling her around in				
		ted that this person was				
		going to the bathroom in				
	her brief. Son w	2 2				
	Review of a "Inc	eident Report Form" dated				
	1/11/12, sent to 1	•				
	· ·	Iealth, indicated, "				
	•	ates she was moved				
		he night by a woman with				
		ice. Upon interview,				
		ates that [CNA # 14] was				
		while rolling her in the				
	_	scolded her for 'making a				
		[4] states she provided				
	-	t # F] gently, and denies				
	_	soiling herself. Staff,				
	residents, and far	milies of residents to				
	•	4] provides care do not				
	_	her care[CNA # 14]				
	suspended pendi	ng investigation.				
		tiated. MD & family				
	_	14] re-educated. She				
	_	d to her position with				
		monitored by nurse				
		provision of care per				
	_	ervices will continue to				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	ì	00	COMPL	
		155219	B. WING			05/04/	2012
NAME OF P	PROVIDER OR SUPPLIER	\ \			ADDRESS, CITY, STATE, ZIP CODE		
KINDDE	TDANCITIONAL (CARE AND REHAB-SOUTH BEN			I IRONWOOD RD		
				, отп	BEND, IN 46635	1	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREF	ıv	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		nt # F's] psychosocial					
	well-being"	ne ii T 5] psychosociai					
	wen comg						
	Review of a facil	lity "Alleged Abuse,					
		loitation Investigation					
		d 1/11/12, indicated,					
	"Physical Abus	seVerbal					
	*	t stated that someone					
	during the night	was being rough c her					
	and rolling her ar	round in her bed roughly.					
	She stated that th	nis person was yelling at					
	her for 'making a	n mess' in her					
	briefCNA susp	pended pending					
	investigation"						
	.						
	_	with the Social Services					
		12 at 2:30 P.M., he					
		rsing staff made him					
		dent the following day.					
		ated the son of Resident					
		ne incident to him the					
		He further indicated he yone told him about the					
	· ·	incident. He indicated					
		e family coming into the					
		months ago to talk with					
		rse and he thought she					
		matter. He further					
		have documented the					
	· ·	he would check. The					
		lacked documentation					
		rice regarding the					
		st was made to the Social					
	_	at this time for any Social					
	l	J	- 1				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155219		(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE (COMPL 05/04/	ETED	
	PROVIDER OR SUPPLIER	L CARE AND REHAB-SOUTH BEND		STREET A 52654 N	DDRESS, CITY, STATE, ZIP CODE I IRONWOOD RD BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Service documer incident.	ntation regarding the					
	As of 5/4/12 at 1 documentation h the Social Service	as been provided from					
	Services undated indicated "Clin Encourages invo and assists family arrangements. P psychosocial interesident's familie Assists resident's others in coping placement, physical disabilities of the grieving process observations and medical record a documents psychevents, health cochange"	lvement in family council y council with meeting rovides direct ervention to residents and es/significant others. Is families/significant with skilled nursing cal illness and e resident, and theDocuments events in the resident's es needed: assesses and hosocial impact of life ncerns and condition					

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Facility ID: 000124

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IC.	00	COMPL	ETED
		155219	A. BUILDIN B. WING	i.		05/04/	2012
				TREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R			IRONWOOD RD		
KINDREI	TRANSITIONAL (CARE AND REHAB-SOUTH BEND			BEND, IN 46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	II)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
F0280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and						
	revised by a team of qualified persons after each assessment. Based on interview and record review, the facility failed to ensure residents were given the opportunity to participate in their plan of care, related to residents and a family members not being invited to participate in care planning meetings, for 2 of 3 residents identified by staff as alert and oriented, interviewed in a total sample of 22 (Residents #38 and #B) and 8 of 9 residents/family members, identified by staff as alert and oriented, interviewed in a supplemental sample of 9. (Residents #14, #22, #39, #50, #88, #91, #94, and #108). Findings include:		F0280		1. Residents B, 14, 22, 39, 50 88, 91, and 108 have been informed of the notification process for residents and famit to attend care planning meetin Residents 38 and 94 have beed discharged from the facility. 2. other residents have the potent to be affected. Interdisciplinary team has notified all residents of the process for invitation to scheduled care planning meetings. 3. The interdisciplinate am has been inserviced on the resident and family notification process and documentation requirements of that notification for scheduled care planning meetings. MDS	lies igs. en All itial n e	06/09/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155219	A. BUII			05/04/	2012
		1.552.5	B. WIN				
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					N IRONWOOD RD		
KINDREI	D TRANSITIONAL	CARE AND REHAB-SOUTH BENI)	SOUTH	BEND, IN 46635		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1. Resident #B 04/30/12 at 1:35 indicated she had not participathe staff planner medical and nur Resident #B's re 05/01/12 at 2:45 diagnoses included to, diabetes mel dementia. A Quarterly Min Assessment, data resident had a min impairment. A, "Care Plan C dated 02/23/12, Resident and/or Plan Conference There was a lact resident's Progret to indicate the resident #38 05/01/12 at 8:55	was interviewed on 5 p.m. The resident and not been invited and atted in meetings where in her activities and daily raing care (care plan). ecord was reviewed on 5 p.m. The resident's ded, but were not limited litus and vascular minum Data Set (MDS) ted 02/09/12, indicated the noderate cognition Conference Summary", lacked documentation the Family attended the Care ec. k of documentation in the tess Notes, dated 02/23/12, tesident had been invited			Coordinator/designee will noticall residents and families of scheduled care planning meetings, so they may participal as desired. 4. MDS Coordinator/designee will auditeresident and family notification scheduled care planning meetings monthly. These auditions will be reviewed monthly X 6 months in the facility's Performance Improvement Committee meeting to ensure 100% compliance.	fy pate it all ns of its	DATE
	had not participate Conferences.	ated in Care Plan					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155219	A. BUI	LDING	00	COMPLI 05/04/2	
		155219	B. WIN			03/04/	2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE N IRONWOOD RD		
KINDREI	D TRANSITIONAL	CARE AND REHAB-SOUTH BEN	ID	1	BEND, IN 46635		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1710	REGUERTORT OF	CESC IDENTIFICATION ON ONLY THOU		ing			BATE
	Recident #38's re	ecord was reviewed on					
		p.m. The resident's					
	diagnoses included, but were not limited						
	to, congestive heart failure and vascular						
	dementia.						
	dementia.						
	A Significant Ch	nange MDS Assessment,					
	dated 02/14/12, indicated the resident's						
	cognition status was intact.						
	A, "Care Plan C	onference Summary",					
	dated 03/20/12,	lacked documentation the					
	Resident and/or	Family attended the Care					
	Plan Conference	.					
		of documentation in the					
	_	ess Notes, dated 03/20/12,					
		esident had been invited					
	to the Care Plan	Conference.					
	3 Resident #39	was interviewed on					
		5 a.m. The resident					
		d not been invited and					
	had not participa						
	Conferences.						
	Resident #39's re	ecord was reviewed on					
	05/01/12 at 2:55	p.m. The resident's					
	diagnoses includ	led, but were not limited					
	to, diabetes mell	itus and hypertension.					
		S Assessment, dated					
	02/06/12, indica	ted the resident's					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155219	B. WIN			05/04/	2012
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
KINIDDEI	D TDANGITIONAL (CARE AND REHAB-SOUTH BEN	חו		N IRONWOOD RD BEND, IN 46635		
			, , , , , , , , , , , , , , , , , , ,		DEND, IN 40035		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	1	oderately impaired.		1110			D.II.D
	cognition was in	inductation impaired.					
	A "Care Plan Co	onference Summary",					
		lacked documentation the					
	Resident and/or Family attended the Care						
	Plan Conference.						
	Plan Conference.						
	There was a lack of documentation in the						
	resident's Progress Notes, dated 02/23/12, to indicate the resident had been invited						
	to the Care Plan Conference.						
	4. Resident #50 was interviewed on						
		.m. The resident					
	_	d not been invited and					
		ated in Care Plan					
	Conferences.	ace in care i ian					
	Comerciaces.						
	The resident's re	cord was reviewed on					
	05/01/12 at 3 p.r	m., The resident's					
	_	led, but were not limited					
	-	and diabetes mellitus.					
	, ,,						
	A Quarterly MD	S Assessment, dated					
		ted the resident's					
	cognition was in						
	A, "Care Plan Co	onference Summary",					
		lacked documentation the					
	-	Family attended the Care					
	Plan Conference	•					
	There was a lack	of documentation in the					
	resident's Progre	ess Notes, dated 02/24/12,					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155219	B. WIN			05/04/	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R			N IRONWOOD RD		
KINDREI	TRANSITIONAL (CARE AND REHAB-SOUTH BENI)		BEND, IN 46635		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	to indicate the re	esident had been invited					
	to the Care Plan	Conference.					
	5. Resident #88	's spouse was interviewed					
	on 04/30/12 at 11:45 a.m. The resident's						
		I she had not been invited					
	and had not participated in Care Plan						
	Conferences.						
	A, "Care Plan Conference Summary",						
	dated 02/22/12, lacked documentation the						
	Resident and/or	Family attended the Care					
	Plan Conference	<i>2.</i>					
	6 During a grou	up interview on 05/01/12					
		sidents #14, #22, #91,					
	_						
		ndicated they had not been					
		not participated in Care					
	Plan Conference	es.					
	l '	1's record was reviewed					
		:30 p.m. The resident's					
	diagnoses includ	led, but were not limited					
	to, Hypertension	and congestive heart					
	failure.	-					
	A Ouarterly MD	S Assessment, dated					
	_ ·	ted the resident's					
	cognition was in						
	Cognition was III	ituot.					
	Δ "Care Plan C	onference Summary",					
	· 1	• •					
		lacked documentation the					
		Family attended the Care					
	Plan Conference	.					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155219		(X2) MULTIPLE CONSTRUCTION A. BUILDING O			(X3) DATE SURVEY COMPLETED 05/04/2012	
		100210	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/04/	2012
NAME OF F	PROVIDER OR SUPPLIER	8			N IRONWOOD RD		
	D TRANSITIONAL (CARE AND REHAB-SOUTH BEN	D		BEND, IN 46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL I SC IDENTIFYING INFORMATION)		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	There was a lack resident's Progreto indicate the reto the Care Plan B) Resident #100 on 05/01/12 at 3 diagnoses include to, late effect her constipation. A Quarterly MD 01/01/12, indicate cognition was in A, "Care Plan Codated 02/09/12, I Resident and/or Plan Conference There was a lack resident's Progreto indicate the reto the Care Plan C) Resident #14' 05/01/12 at 2:55 diagnoses include to, hypertension A Significant Chemostra in the Care Plan conference of the Care Plan	8's record was reviewed 35 P.M. The resident's led, but were not limited miplegia and S Assessment, dated ted the resident's tact. Inference Summary", lacked documentation the Family attended the Care of documentation in the ss Notes, dated 02/09/12, esident had been invited Conference. S record was reviewed on p.m. The resident's led, but were not limited and spinal stenosis. Inange MDS Assessment, indicated the resident's		TAG	DEFICIENCY)		DATE

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155219		A, BUILDING 00			COMPL	X3) DATE SURVEY COMPLETED 05/04/2012	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE N IRONWOOD RD			
KINDREI	TRANSITIONAL (CARE AND REHAB-SOUTH BENE						
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	DATE	
TAG	A, "Care Plan Codated 03/06/12, I Resident and/or Plan Conference There was a lack resident's Progreto indicate the reto the Care Plan D) Resident #22 on 05/01/12 at 3 diagnoses include to, hypertension A Quarterly MD 04/06/12, indicate cognition was in A, "Care Plan Codated 04/12/12, I Resident and/or Plan Conference There was a lack resident's Progreto indicate the reto the Care Plan	onference Summary", lacked documentation the Family attended the Care. It of documentation in the ss Notes, dated 03/06/12, sident had been invited Conference. It's record was reviewed and the conference sed, but were not limited and diabetes mellitus. S Assessment, dated the resident's tact. In onference Summary", lacked documentation the Family attended the Care of documentation in the ss Notes, dated 04/12/12, sident had been invited Conference.		TAG	DEFICIENCY)		DATE	
	on 05/01/12 at 3 diagnoses includ	's record was reviewed :45 p.m. The resident's ed, but were not limited and prostate cancer.						

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND 52654 N IRONWOOD RD SOUTH BEND, IN 46635	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMP.	(X5) PLETION ATE
An Admission MDS Assessment, dated 02/01/12, indicated the resident's cognition was moderately impaired. A, "Care Plan Conference Summary", dated 03/29/12, lacked documentation the Resident and/or Family attended the Care Plan Conference. There was a lack of documentation in the resident's Progress Notes, dated 03/29/12, to indicate the resident had been invited to the Care Plan Conference. During an interview on 05/01/12 at 11:30 a.m., MDS nurse #5 indicated the Receptionist sends invitations to the resident's family prior to the Care Plan Conference meetings. She indicated they do not keep copies of the letters and do not document the invitation in the chart. She indicated the residents' families are invited, not the residents. She indicated there is no documentation the residents have been invited to the Care Plan Conference. 3.1-35(d)(2)	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE			ETED	
		155219				05/04/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.			N IRONWOOD RD		
KINIDDEE	TDANCITIONAL (CADE AND DELIAD COUTH DEND			I BEND, IN 46635		
KINDKEL	TRANSITIONAL (CARE AND REHAB-SOUTH BEND	'	30011	1 BEND, IN 40033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=E	483.20(k)(3)(ii) SERVICES BY COARE PLAN The services profacility must be profacility must be profacility failed to were transcribed residents received ordered by the planscribe of the practice affected reviewed for measurable of 22. Resident # C, # In Findings include 1. The clinical rewas reviewed on The resident's diameter was reviewed on The resident's diameter was admitted to the clinical recombination.		F02	**************************************	1. For Residents H and I, MD has clarified the order and corrections have been made to the clinical record as ordered. Residents C and J have been discharged from the facility. 2. other residents have the potent be affected. Pharmacy has audited all residents clinical records for transcription errors that may have occurred in the 2 months with corrections made by the Unit Managers per Kind policy and procedure. 3. Licensed nurses have been inserviced on policies and procedures related to transcription of physician's orders will be verified by a second nurse to ensure accuracy. 4. Unit Managers ward audit all transcription of physician's orders for accuracy. These audits will be reviewed monthly X 6 months in the facility's Performance Improvement Committee meet to ensure 100% compliance.	All atial solutions are defined fill y.	DATE 06/09/2012
	Discharge Inform	nation" dated 4/6/12,			to crisure 100 % compliance.		
	_	reglinide (diabetes					
	-	ng (milligrams) oral					
	,						
	tabletbefore me	ears"					

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Event ID: NHV811

Facility ID: 000124

If continuation sheet Page 46 of 69

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155219	B. WIN	G		05/04/2012	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
KINDDE	TDANIOITIONAL (DADE AND DELIAD COLITILIDES	n		I IRONWOOD RD		
KINDREL	J TRANSITIONAL (CARE AND REHAB-SOUTH BEN	טו	SOUTH	BEND, IN 46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE	
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEI ICIENCT)	DATE	
		cility "Admission Orders					
		ation" dated 4/6/12,					
	indicated, "Nateglinide 60 mg p.o.						
	(orally) before bed2100 (9:00 P.M.)"						
	Davious of the "Medication Decord"						
	Review of the "Medication Record"						
	· · · · · · · · · · · · · · · · · · ·	ed Resident # I received					
		nteglinide 60 mg each day					
	at 9:00 P.M. fror	m 4/7/12 thru 4/30/12.					
		ysician's Telephone					
	Orders" dated 4/						
	· · ·	glinide) 60 (mg) c (with)					
	meals, breakfast	& dinner"					
		Medication Record"					
		ed Resident # I received					
		ateglinide 60 mg each day					
		15:00 P.M. from 4/15/12					
	thru 4/30/12.						
	During interview	with the DON on $5/3/12$					
	at 2:20 P.M., she	identified the above					
		ion records as April					
	2012.						
		Diabetic Monitoring Flow					
	Sheet" indicated	Resident I's blood sugar					
	ranged from 81 t	o 125 from 4/7/12 thru					
	4/30/12.						
		ay 2012, "Medication					
	Record" lacked of	locumentation of the					
	order for Nategli	nide 60 mg with meals,					
	breakfast & dinn	er.					

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Event ID: NHV811

Facility ID: 000124

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155219	A. BUII B. WIN			05/04/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			N IRONWOOD RD		
KINDRE	O TRANSITIONAL (CARE AND REHAB-SOUTH BEND)		BEND, IN 46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	During interview 5/1/12 at 12:00 F Resident # I did morning dose of because it had no MAR (medication) During interview 5/1/12 at 12:05 F nurses are to verifor accuracy. She made the error benumerous admissional Review of a Careblood sugars R/T (diagnoses) of did indicated, "Admordered" 2. The clinical rewas reviewed on resident's diagnonot limited to: he hyperlipidemia, at the clinical recowas originally accreadmitted 4/27/	with LPN # 11 on P.M., she indicated not receive the scheduled Nateglinide on 5/1/12 of been transcribed on the on administration record). with LPN # 10 on P.M., she indicated two ify the transcribed orders are further indicated she ecause she was busy with sions that day. Plan titled "Unstable Telefated to) Dx. abetes" dated 4/12/12, minister medications as ecord for Resident # H 1.5/1/12 at 3:30 P.M. The ses included, but were ypothyroidism, and acute renal failure. In didicated Resident # H Idmitted 12/11/08 and 12.		TAG	DEFICIENCY)		DATE
	Discharge Inform	Name) Hospital "Patient nation" dated 4/27/12, othyroxine (Synthroid)					

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Event ID: NHV811

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155219	B. WIN			05/04/	2012
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE N IRONWOOD RD		
KINDREI	O TRANSITIONAL	CARE AND REHAB-SOUTH BENI)		I BEND, IN 46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		
TAG		R LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCT)		DATE
	(thyroid medicat						
	(micrograms), oral, Mon (Monday) - Fri (Friday)levothyroxine (Synthroid) 50						
	l ` • • •						
	_	t (Saturday) and Sun					
	(Sunday)"						
	Review of the fo	acility "Admission Orders					
		/26/12, indicated,					
		mcg p.o. (orally) on Sat					
	I -						
	& Sun" The Admission Orders transcribed by the nurse lacked						
	documentation of the ordered Synthroid						
		day through Friday.					
	75 meg for Mon	day imough i naay.					
	Review of the 4	/26/12 thru 4/30/12 MAR					
	and May 2012 N						
	_	of the ordered Synthroid					
	75 mcg.	or the ordered symmetry					
	, e meg.						
	During interview	v with LPN # 10 on					
	5/1/12 at 4:00 P.	M., she indicated she was					
	the nurse who fa	illed to properly transcribe					
		orders. She further					
	indicated the ord	lers are to be double					
	checked and that	t Resident # H's orders					
	were doubled ch	ecked for accuracy as					
		nurses signatures on the					
	admission order	_					
	acknowledged R	Resident # H failed to					
	receive the order	red Synthroid 75 mcg for					
	4 days.						
		record for Resident # C					
	was reviewed or	n 5/2/12 at 2:00 P.M. The					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED	
		155219	B. WIN			05/04/	2012	
			1		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIEF	₹			N IRONWOOD RD			
KINDREI	O TRANSITIONAL (CARE AND REHAB-SOUTH BENI)	SOUTH	BEND, IN 46635			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IATE CONTENTION		
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		oses included, but were						
		lepression, osteoporosis,						
	and chronic back pain.							
	The clinical record indicated Resident # C							
	was admitted 1/5	5/12.						
	Review of the (N	Name) Hospital "Patient						
	Discharge Inforr	nation" dated 1/5/12,						
	indicated, "ari	piprazole (Abilify 20						
	mg) (anti depressive medication)1 tab, oral, once a day (at bedtime)"							
		,						
	Review of the fa	cility "Admission Orders						
		/5/12, indicated a nurse						
		nedication to be given						
		g PO (orally) Q (every)						
	'	A.M.)" instead to be						
	,							
	_	e as ordered by the						
	physician.							
	Review of the In	nuary 2012, MAR						
		ent # C received the						
		fy at 7:30 A.M. instead of						
	1	at bedtime, January 6th						
	through the 23rd	1 01 2012.						
	Desain a last							
		w with the DON on 5/2/12						
		e indicated the resident						
		lify at 7:30 A.M. due to a						
	transcription erro							
	4. The clinical r	record for Resident # J						
	was reviewed on	n 5/2/12 at 10:55 A.M.						
	The resident's di	agnoses included, but						

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	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DATE SU COMPLET	
ANDILAN	OI CORRECTION	155219		ILDING	00	05/04/20	
			B. WI		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				I IRONWOOD RD		
KINDREI	O TRANSITIONAL (CARE AND REHAB-SOUTH BEI	ND	SOUTH	BEND, IN 46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1110		to: gastroesophageal		1110		<u> </u>	D.T.L
	reflux disease, hy						
	hypothyroidism.						
	The clinical record indicated Resident # J						
	was admitted to	the facility on 4/20/12.					
	Review of the (N	Jame) Hospital "Patient					
	` `	nation" dated 4/20/12,					
		toprazole (Protonix					
(reflux medication) 40 mg (milligrams)							
	oral enteric coated tablet), oral, 2 times a						
	day"						
	Davious of the fo	aility "Admission Orders					
		cility "Admission Orders tion" dated 4/20/12,					
		tonix 40 mg PO (orally)					
	Q day (every day	9 ()					
		Medication Record" dated					
		0/12, indicated Resident #					
		heduled Protonix 40 mg					
	each day at 7:30 4/30/12.	A.M. from 4/20/12 thru					
	4/3U/12.						
	During interview	on 5/2/12 at 2:26 P.M.,					
	-	ted Resident # J did not					
	receive the Proto	nix as ordered by the					
	physician.						
	Daniana C. C. C.	lika a 1 i a kik1 a .1					
	Review of a facil	and Written Orders,					
	· · · · · · · · · · · · · · · · · · ·	Orders or Faxed Orders"					
		, indicated, "Physician					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155219		A. BUILDING B. WING	00	COMI	COMPLETED 05/04/2012	
	PROVIDER OR SUPPLIER	L CARE AND REHAB-SOUTH BEN	STREET A 52654 I	ADDRESS, CITY, STATE, ZIP CON IRONWOOD RD I BEND, IN 46635	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	incorrectly conti prevent transcrip	revent missing an order, nuing an order of to				
	IN00105618. 3.1-35(g)(2)	Tourist to Companie				

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Event ID: NHV811

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	A X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155219	A. BUIL B. WIN			05/04/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				N IRONWOOD RD		
KINIDDEL	TDANSITIONAL (CARE AND REHAB-SOUTH BEND			I BEND, IN 46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0322	483.25(g)(2)						
SS=D		T/SERVICES - RESTORE					
	EATING SKILLS						
		mprehensive assessment of acility must ensure that a					
		ed by a naso-gastric or					
		e receives the appropriate					
		ervices to prevent aspiration					
		rhea, vomiting, dehydration,					
	metabolic abnorr	malities, and					
		ll ulcers and to restore, if					
	possible, normal	eating skills.					
	Based on observa	ations, interviews and	F03	22	1. For Resident 30, the		06/09/2012
	record review, th	e facility failed to ensure			positioning of the Resident wa		
	a resident with a	history of aspiration			corrected during the survey. 2		
		vith a feeding tube, had			All residents with gastrostomy tubes have the potential to be		
	•	levated while her gastric			affected. All residents with		
	* *	<u> </u>			gastrostomy tubes have been		
		as running, for 1 of 3			reviewed by therapy for bed		
		ed receiving gastric tube			positioning requirements and		
	•	nple of 22. (Resident #			plans of care for these residen		
	30)				have been updated to reflect to		
					requirements. 3. All nursing si	tatt	
	Findings include	:			have been inserviced on the positioning requirements for		
					residents with gastrostomy tub	ne.	
	During a tour of	the unit on 4/30/12 at			feedings. Department heads w		
	11:10 a.m., an ob	oservation was made of			perform randomly timed audits		
	Resident # 30 in	a low bed. The head of			per week on all shifts to ensure		
		erved elevated, but the			compliance with positioning		
		ad slid down in the bed,			requirements. 4. DNS will trac		
	•	-			and trend audit results. Result	s of	
	-	area in a flat position.			these audits will be reviewed monthly X 6 months in the		
		vas made of a feeding			facility's Performance		
		to the resident and the			Improvement Committee meet	ina	
		50 cc an hour. LPN # 1			to ensure 100% compliance.		
	was summoned t	o observe the resident at			,		
	this time. LPN #	1 took the bed controls					
	and elevated the	bed until the resident's					
	c.c . acca the						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155219	B. WIN			05/04/	2012
NAME OF B	DROVIDED OD GUDDUIE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	· ·		52654 N	N IRONWOOD RD		
KINDREI	O TRANSITIONAL (CARE AND REHAB-SOUTH BEN	D	SOUTH	BEND, IN 46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		C LSC IDENTIFYING INFORMATION)		TAG	DEI (CLENCT)		DATE
		in the correct position to					
	prevent aspiration	on.					
	D :1 . // 201						
		record was reviewed on					
		p.m. The resident's					
		diagnoses of, but not					
		nagia, malaise, fatigue and					
	history of falls.						
	The resident's quarterly MDS (Minimum						
	· · · · · · · · · · · · · · · · · · ·	ment dated 4/13/12,					
		gnition was moderately					
	_	eeded extensive assistance					
	with 2 staff for the	ransfers and total					
	assistance with 1	staff for dressing and					
	bathing.						
		History and Physical					
	Exam" dated 11/						
	"(Resident # 30)	was recently seen					
	actually 7 month	ns ago and has been doing					
	well since she go	ot her last PEG					
	(Percutaneous E	ndoscopic Gastrostomy)					
	tube in, comes ir	n with what appears to be					
	aspirationRigh	t upper lobe infiltrate					
	consistent with p	oneumonia and she has					
	been on Xosyn a	and vancomycin					
	(antibiotics), but	is afebrile almost					
	immediately con	sistent with probable					
	aspiration as is h	ner chronic track					
	recordDiagnos	etic Impression:					
	Aspiration pneur	_					
	A physician's or	der dated 1/18/12 to					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155219	B. WIN			05/04/	2012
			D. (11)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			N IRONWOOD RD		
KINDREI	TRANSITIONAL (CARE AND REHAB-SOUTH BEN)		BEND, IN 46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	current, indicate	d " Head of bed elevated					
	30 degrees at all	times while feeding is					
	running and for	1 hour after					
	completion"						
	• • • • • • • • • • • • • • • • • • •						
	The regident's nl	an of care dated 1/27/12					
	_						
	,	ident # 30) has the					
	_	allowing difficulty and					
		rition status r/t (related to)					
		nsons, dementia, hx					
	l '	ght loss, hx of aspiration.					
	Resident is NPO	(nothing by mouth).					
	Interventions inc	licated "HOB (head of					
	bed) 30 degrees	as ordered, monitor for					
	s/s (signs and sy	mptoms) aspiration"					
		1 / 1					
	The facility's pol	licy and procedure titled					
		g: Pump Method (Open or					
	·	dated 2/24/12 was					
	I						
		/12 at 2:00 p.m. The					
		"9. Elevate the head of					
		5 degree angle during					
	~	at least one-hour after					
	feeding is stoppe	ed"					
	3.1-44(a)(2)						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155219	B. WIN	G		05/04/	2012
	PROVIDER OR SUPPLIER D TRANSITIONAL (CARE AND REHAB-SOUTH BENI)	52654 1	ADDRESS, CITY, STATE, ZIP CODE N IRONWOOD RD I BEND, IN 46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
F0323 SS=G	The facility must environment rem hazards as is poreceives adequa assistance device. Based on intervie facility failed to proper protocol was resident with a Himinipury and transfer Emergency Departments of her lowers ample of 22. Resident # D Findings include The clinical recorreviewed on 5/3/resident's diagnor not limited to: diffracture, dementing Review of a SBA (Situation-Backgommendation) Physical Progress Not indicated, "sweshin & leg/foot to	ensure that the resident nains as free of accident ssible; and each resident te supervision and es to prevent accidents. Ew and record review, the ensure a CNA followed while transferring a loyer lift which resulted asportation to the artment for treatment of a wer leg, for 1 of 2 ed for fractures in a ses included, but were istal tibia and fibula ia, and aphasia. AR ground-Assessment-RecoysicianCommunication	F03	23	1. Resident D was discharged from the facility prior to the survey. CNA # 12 was termina from employment with the faciliprior to the survey. Certified Nursing Assistant competencia for mechanical lift transfers we performed at the time of discovery of the improper transfer. 2. All residents using hoyer lifts have the potential to affected. 3. Certified Nursing Assistants have been inservice on use of mechanical lifts per Kindred policy and procedure have performed return demonstration. Certified Nursin Assistants will use 2 trained st for all mechanical lift transfers. Unit Managers will perform 5 random of observations per we of mechanical lift transfers on shifts. 4. DNS will track and traudit results. Results of these audits will be reviewed monthly 6 months in the facility's Performance Improvement Committee meeting to ensure 100% compliance. The facility respectfully requests an IDR for the severity of this citation. The event cited did not lead to the injury as cited as per facility investigation of the event.	ated lity es ere b be ed and ng aff eek all end y X	06/09/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155219	B. WIN	G		05/04/2012
NAME OF F	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					I IRONWOOD RD	
KINDREI	D TRANSITIONAL (CARE AND REHAB-SOUTH BEN	D	SOUTH	BEND, IN 46635	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
		r when she noticed that				
		wollen. I assessed shin &				
	_	oted to area. No trauma				
	noted. Skin of n	ormal color, no redness,				
	warmth noted. R	R leg laying on bed c				
	(with) foot turned	d out"				
	Review of a "Fac	cility Incident Reporting				
	Form" dated 9/20	0/11, indicated, "				
	(Resident # D) w	as observed by staff to				
	be laying in bed.	Her right lower leg				
	appeared deform	edInterviews reveal				
	(Resident # D) h	ad been laid down for				
	bed per Hoyer lif	ft 20-30 minutes prior to				
	discovery. CNA	caring for (Resident #				
	D) states she was	s unaware of injury.				
	· ·	care plan listed Hoyer lift				
		o other staff observed				
	anvone else in (F	Resident # D's) room in				
		een transfer to bed and				
		nactment of the transfer				
	1	NA performed the				
		ent # D) returned from				
		right lower leg"				
	Zit wim spinited					
	Review of a Rad	iology Report dated				
		d, "There is an acute				
	•	through the distal tibial				
		anterolaterally displaced				
	1	the distal fibular				
	metadiaphysis'					
	inctadiaphysis					
	Review of an una	dated internal facility				
		n CNA # 12, indicated,				

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Event ID: NHV811

Facility ID: 000124

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155219		ĺ	LDING G	ONSTRUCTION 00	(X3) DATE COMPL 05/04	ETED	
	PROVIDER OR SUPPLIE D TRANSITIONAL	R CARE AND REHAB-SOUTH BEN	D	52654 N	ADDRESS, CITY, STATE, ZIP CODE N IRONWOOD RD I BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	"I did not hav transfer"	e assistance with the					
	Form" dated 9/2 # 12)Failure to Hoyer transfers 9/19/11 without may have lead to fracture to tibia Review of Resident with a daily living)"" "Hoyer lift for the Resident # D's Soot (Minimum Data 8/30/11 indicated severely impair assistance with transfers and base indicated she rewith 2 staff assist MDS indicated history of falls. Review of a face "Mechanical Li 3/6/12, indicated from another staff and the rewith a staff assist mechanical Li 3/6/12, indicated from another staff and the rewith a staff assist mechanical Li 3/6/12, indicated from another staff and the rewith a staff assist mechanical Li 3/6/12, indicated from another staff and the rewith a staff assist mechanical Li 3/6/12, indicated from another staff and the rewith a staff assist mechanical Li 3/6/12, indicated from another staff and the rewith a staff assist mechanical Li 3/6/12, indicated from another staff and the rewith a staff assist mechanical Li 3/6/12, indicated from another staff and the rewith a staff assist mechanical Li 3/6/12, indicated from another staff and the rewith a staff assist mechanical Li 3/6/12, indicated from another staff and the rewith a staff assist mechanical Li 3/6/12, indicated from another staff assis mechanical Li 3/6/12, indicated from another staff assist mechan	dent #D's care plan titled Il ADL's (activities of ' dated 8/30/11, indicated, r all transfers" Significant change MDS a Set) assessment dated ed her cognition was ed. She needed total 2 staff assistance with thing. The MDS quired a mechanical lift stance for transfers. The the resident did not have a ility policy titled ft (Sling Lift)" revised d, "Obtain assistance aff member for transfer as to people are required when					

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Event ID: NHV811

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155219	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/04/2012
	PROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHAB-SOUTH BEND	52654 N	ADDRESS, CITY, STATE, ZIP CODE N IRONWOOD RD I BEND, IN 46635	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Review of a facility policy titled "Accidents and Supervision to Prevent Accidents" revised 4/28/11, indicated, "Center provides appropriate assistive devices to reduce the risk and/or prevent accidents. Ways to reduce risk and/or prevent risk are: Education of the staff in using assistive devices properlyPatient who becomes frightened during transfer in a mechanical lift may exhibit resistance movements that result in avoidable accidents" This Federal tag relates to Complaint IN00107648. 3.1-45(a)(2)			

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Facility ID: 000124

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155219		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/04/2012	
	PROVIDER OR SUPPLIE D TRANSITIONAL	CARE AND REHAB-SOUTH BENE	52654 1	ADDRESS, CITY, STATE, ZIP CODE N IRONWOOD RD I BEND, IN 46635	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0368 SS=E	BEDTIME Each resident reprovides at least times comparable community. There must be repetiveen a substantial to affect to affect the provided below. The facility must daily. When a nourish bedtime, up to 1 a substantial every following day if a this meal span, served. Based on intervirual facility failed to offered snacks a residents, identification oriented, intervirual (Residents #38 residents, identification) as the potential to affect the provides and t	ing snack is provided at 6 hours may elapse between ening meal and breakfast the a resident group agrees to and a nourishing snack is ew and record review, the ensure residents were t bedtime daily for 3 of 3 fied by staff as alert and ewed in a total sample of 38, #71, and #B) and 7 of tified by staff as alert and ewed in a supplemental esidents #14, #22, #37, and #94). This had the ct 105 residents with oral reside in the healthcare	F0368	1. For Residents B, 14, 22, 37, 39, 50, and 91, education was provided related to facility procedure for offering of HS snacks. Residents 38, 71, and have been discharged from th facility. 2. All residents who receive an HS snack have the potential to be affected. Interdisciplinary team has interviewed all residents to ensure HS snacks are being offered, with teaching provided the procedure for those who a not aware.3. Licensed Nurses have been inserviced on the policy and procedure for offeri HS snacks. Licensed nurses woffer an HS snack during HS repass daily. Department Heads	d on re s

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Event ID: NHV811

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[·		(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
		A. BUILDING COMPLET			ETED		
155219		B. WING			05/04/	2012	
NAME OF T	DOLUDED OF GURNING	1	STR	EET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		526	54 N	I IRONWOOD RD		
		CARE AND REHAB-SOUTH BEN		UTH	BEND, IN 46635		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		interview 5 residents weekly to		DATE
		vas interviewed on			determine if they are being)	
		p.m. The resident			offered HS snacks. 4. DNS w	vill	
		es not get offered a			track and trend the interview		
	bedtime snack.				results. These results will be		
					reviewed monthly X 6 months	in	
	Resident #B's red	cord was reviewed on			the facility's Performance	tina	
	05/01/12 at 2:45	p.m. The resident's			Improvement Committee meet to ensure 100% compliance.	urig	
		ed, but were not limited			to choure 100 /0 compliance.		
	to, diabetes melli						
	dementia.						
	A Quarterly Min	imum Data Set (MDS)					
		ed 02/09/12, indicated the					
	-	oderate cognition					
		oderate cognition					
	impairment.						
	2. Resident #38 v	was interviewed on					
	05/01/12 at 8:55	a.m. The resident					
		es not get offered a					
		the indicated if she asks					
	for one, she will						
	ioi one, siie wiii	Soi a shack.					
	Resident #38's re	ecord was reviewed on					
		p.m. The resident's					
		•					
	_	ed, but were not limited					
	_	art failure and vascular					
	dementia.						
	A Significant Ch	ange MDS Assessment,					
	_	ndicated the resident's					
	cognition status						
	Cognition status	was mact.					
	 3 Resident #39 v	was interviewed on					
		5 a.m. The resident					
	0 1/20/12 at 10.2.	1110 1001U011t	Ī	- 1			1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
│ 155210		B. WIN			05/04/	2012	
			Б. W II V		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			N IRONWOOD RD		
KINDREI	O TRANSITIONAL (CARE AND REHAB-SOUTH BEN	D		BEND, IN 46635		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORREC			(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated she do	es not get offered a					
	bedtime snack. S	She indicated if you ask					
	for a snack, they	will bring her fruit.					
	Resident #39's re	ecord was reviewed on					
	05/01/12 at 2:55	p.m. The resident's					
	diagnoses includ	led, but were not limited					
	_	itus and hypertension.					
		71					
	A Quarterly MD	S Assessment, dated					
	02/06/12, indicat	ted the resident's					
		oderately impaired.					
	4 Resident #50 y	was interviewed on					
		.m. The resident					
		es not get offered a					
		the indicated if she wants					
	a snack, she has	to ask for it.					
	The resident's re-	cord was reviewed on					
	05/01/12 at 3 p.n	n., The resident's					
	_	led, but were not limited					
		and diabetes mellitus.					
	,, perconsisti						
	A Quarterly MD	S Assessment, dated					
	02/13/12, indicat	*					
	cognition was in						
	Cognition was in	iaci.					
	5. Resident #37	was interviewed on					
		a.m. The resident's					
		led, but were not limited					
	"	·					
	io, biadder cance	er and hypothyroidism.					
	An Admission N	IDS Assessment, dated					

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Event ID: NHV811

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i i		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155219		A. BUI	LDING	00	COMPL: 05/04/		
100219			B. WIN		PRESIDENCE OF THE CORP.	03/04/	2012
NAME OF P	PROVIDER OR SUPPLIER	8		1	ADDRESS, CITY, STATE, ZIP CODE I IRONWOOD RD		
KINDREI	O TRANSITIONAL (CARE AND REHAB-SOUTH BEN	ID		BEND, IN 46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1710	04/23/12, indicat	· · · · · · · · · · · · · · · · · · ·		1110			DATE
	cognition was in						
	6. During a grou	ip interview on 05/01/12					
	at 1:45 p.m., Res	sidents #14, #22, #71 #91,					
	and #94 indicate	d they do not get offered					
	a snack at bedtin	ne.					
	A) D 1 / //01	to					
	· ·	's record was reviewed 30 p.m. The resident's					
		ed, but were not limited					
	-	and congestive heart					
	failure.	and congestive heart					
	iditale.						
	A Quarterly MD	S Assessment, dated					
	04/10/12, indicat						
	cognition was in	tact.					
	· ·	record was reviewed on					
		P.M. The resident's					
	•	ed, but were not limited					
		inhalation and respiratory					
		lent was admitted into the					
	facility on 04/20	/12.					
	The Admission/	5-day MDS Assessment,					
		idicated the resident's					
	cognition was in						
	C) Resident #14'	s record was reviewed on					
	05/01/12 at 2:55	p.m. The resident's					
	_	ed, but were not limited					
	to, hypertension	and spinal stenosis.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
155219			ILDING	00	05/04/		
1.552.15			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	30/04/	
NAME OF F	PROVIDER OR SUPPLIER	t .		1	I IRONWOOD RD		
		CARE AND REHAB-SOUTH BEN	ND		BEND, IN 46635		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
		ange MDS Assessment,					
	•	indicated the resident's					
	cognition was in						
	D) Resident #22	e's record was reviewed					
	on 05/01/12 at 3:	:00 p.m. The resident's					
	_	ed, but were not limited					
	to, hypertension	and diabetes mellitus.					
		S Assessment, dated					
	04/06/12, indicat						
	cognition was in	tact.					
	 E) Resident # 94	's record was reviewed					
	l '	:45 p.m. The resident's					
		ed, but were not limited					
	•	and prostate cancer.					
	An Admission M	IDS Assessment, dated					
	02/01/12, indicat						
	cognition was me	oderately impaired.					
	During on inter-	iow on 05/01/12 at 11:20					
		iew on 05/01/12 at 11:20 r of Nursing indicated the					
		ed to offer the residents a					
	bedtime snack.	a to offer the residents a					
	- James Bilacit.						
	During an interv	iew on 05/01/12 at 4:40					
	_	dicated she gave the					
	_	if they asked for them.					
	She indicated she	e did not offer snacks.					
	1	iew on 05/01/12 at 4:45					
	I p.m CNA #7 in	dicated if the residents	1				

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PRINTED: 06/13/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 155219	(X2) MULTIPLE COI A. BUILDING B. WING	00	COMPLE S 05/04/	ETED
	PROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHAB-SOUTH BEND	STREET A 52654 N	DDRESS, CITY, STATE, ZIP CODE I IRONWOOD RD BEND, IN 46635	1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	Е	(X5) COMPLETION DATE
	ask for snacks then she will give them a snack. She indicated they only give snacks if the residents ask for them. During an interview on 05/01/12 at 4:45				
	p.m., CNA #8 indicated she will ask the residents if they would like a snack.				
	3.1-21(e)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
155210		A. BUII B. WIN			05/04/	/2012	
		<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R			N IRONWOOD RD		
KINDREI	O TRANSITIONAL (CARE AND REHAB-SOUTH BEND)		H BEND, IN 46635		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0498 SS=G	483.75(f) NURSE AIDE D						
	COMPETENCY						
	•	t ensure that nurse aides are rate competency in skills and					
		essary to care for residents'					
		fied through resident					
		nd described in the plan of					
		ew and record review, the	F04	98	Resident D was discharged	d	06/09/2012
	facility failed to	•			from the facility prior to the		
	_	empetency and followed			survey. CNA # 12 was terminate from employment with the faci		İ
		while transferring a	prior to the surv Nursing Assista for mechanical		prior to the survey. Certified Nursing Assistant competencies		
		Hoyer lift, which resulted					
	in a fracture requ	uiring emergency room			for mechanical lift transfers we	ere	
	•	of 6 residents reviewed			performed at the time of discovery of the improper		
		f a mechanical lift in a			transfer. 2. All residents using	נ	
	sample of 22.				hoyer lifts have the potential to	•	
	•				affected. 3. Certified Nursing		
	Resident # D				Assistants have been inservic on use of mechanical lifts per Kindred policy and procedure		
	Findings include	e:			have performed return		
					demonstration. Certified Nursi	•	
	1. The clinical r	record for Resident # D			Assistants will use 2 trained st for all mechanical lift transfers		
	was reviewed on	n 5/3/12 at 10:30 A.M.			Unit Managers will perform 5	•	
	This resident's d	iagnoses included, but			random of observations per w		
	were not limited	to: distal tibia and fibula			of mechanical lift transfers on		
	fracture, dement	ia, and aphasia.			shifts. 4. DNS will track and tr audit results. Results of these		
					audits will be reviewed monthl		
	Resident # D's S	ignificant change MDS			6 months in the facility's	-	
	(Minimum Data	Set) assessment dated			Performance Improvement		
	`	d her cognition was			Committee meeting to ensure		
		ed. She needed total			100% compliance. The facility respectfully requests an IDR for		
		2 staff assistance with			the severity of this citation. Th		
					event cited did not lead to the	C	
	transfers and bathing. The MDS				iniury as cited as per facility		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE COMPL	ETED	
		155219	B. WIN			05/04/	2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND			D	52654 N	DDRESS, CITY, STATE, ZIP CODE NIRONWOOD RD BEND, IN 46635		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	with 2 staff assis	uired a mechanical lift tance for transfers. The he resident did not have a			investigation of the event.		
	"Assist with all	lent # D's care plan titled ADL's (activities of lated 8/30/11, indicated, all transfers"					
	Form" dated 9/20 (Resident # D) w be laying in bed. appeared deform	cility Incident Reporting 0/11, indicated, " ras observed by staff to Her right lower leg edInterviews reveal					
	bed per Hoyer lift discovery. CNA D) states she was (Resident # D's)	ad been laid down for ft 20-30 minutes prior to caring for (Resident # s unaware of injury. care plan listed Hoyer					
	anyone else in (R the interim betwee discovery. Re-en	No other staff observed Resident # D's) room in een transfer to bed and nactment of the transfer NA performed the					
	transfer. (Reside ER with splinted	ent # D) returned from right lower leg" iology Report dated					
	9/20/11, indicate the distal tibia an	d, "Acute fracture of d fibula"					
	Review of a facility investigation/interior	lity erview dated 9/20/11,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
155219		A. BUILDING 00 COMPLETED 05/04/2012					
100210			B. WIN		DDDEGG CITY CTATE 7ID CODE	03/04/	2012
NAME OF P	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
KINDREI	O TRANSITIONAL (CARE AND REHAB-SOUTH BEN	ID		BEND, IN 46635		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	COMPLETION DATE
1710		NA # 12) took care of		1110			BITTE
		oday 9/20/11 from 6 A.M.					
		she transferred resident by					
		Hoyer lift. She did not					
	` ′	(UM) (unit manager)					
		ance. States resident did					
	*	ed & showed no pain"					
	-	_					
	Review of an un	dated internal facility					
		n CNA # 12, indicated,					
		assistance with the					
	transfer"						
	Review of a "Per	rformance Improvement					
		3/11, indicated, "(CNA					
		follow procedure for					
		transfer of residents on					
	1 -	assistance. This failure					
		o injury of (Resident # D):					
	fracture to tibia a						
		# 12's personnel file					
		eeived training and					
		d to mechanical lifts on					
	1/28/11.						
	Review of a faci	lity policy titled					
		t (Sling Lift)" revised					
		l, "Obtain assistance					
	· ·	ff member for transfer as					
		people are required when					
	using the Mecha						
	This Federal tag	relates to Complaint					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING							
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
	TRANSITIONAL C	CARE AND REHAB-SOUTH BEND		N IRONWOOD RD I BEND, IN 46635					
(X4) ID PREFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE				
1710		ESC IDENTIFIEND INFORMATION)	170	,	DATE				
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NHV811

Facility ID: 000124

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